# Complete Summary

## GUIDELINE TITLE

Identification and ambulatory care of HIV-exposed and -infected adolescents.

## BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents. New York (NY): New York State Department of Health; 2004 Nov. 22 p. [21 references]

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents. New York (NY): New York State Department of Health; 2003. 21 p.

## COMPLETE SUMMARY CONTENT



## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Acquired immune deficiency syndrome (AIDS)
- General physical, psychological, sexual, and psychosocial health

### GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management

Prevention
Risk Assessment
Screening

## CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychiatry
Psychology

## INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

## GUIDELINE OBJECTIVE(S)

To provide guidelines for the identification and ambulatory care of human immunodeficiency virus (HIV)-exposed and -infected adolescents

## TARGET POPULATION

Human immunodeficiency virus (HIV) exposed and HIV infected adolescents and young adults between the ages of 13 and 24 years

## INTERVENTIONS AND PRACTICES CONSIDERED

### Diagnosis/Evaluation

1. Identification of human immunodeficiency virus (HIV)-infected adolescents through counseling, HIV testing, and risk assessment
2. Referrals to mental health services
3. Baseline medical history
4. Baseline physical examination, including neurologic analysis
5. Baseline laboratory evaluation (HIV antibody, immunologic, virologic, and tuberculosis assessment), including additional baseline tests and tests for sexually active adolescents
6. Immunizations (when clinically indicated), including measles-mumps-rubella (MMR), hepatitis B, tetanus booster (Td), pneumococcal vaccine, influenza vaccine, hepatitis A vaccine, varicella vaccine, meningococcal vaccine

7. Ongoing evaluation, including comprehensive annual examination, routine visits every 3 months, routine laboratory evaluations, and counseling
8. Ongoing psychosocial assessments (e.g., housing, education, family, sexual partners, safe sex practices, drug use, parenting skills)
9. Caring for special adolescent populations (perinatally infected, gay adolescents, transgendered, pregnant, substance-using, and homeless)
10. Referrals to drug treatment programs, community-based organizations, counseling and support programs

### MAJOR OUTCOMES CONSIDERED

- Risk and incidence of human immunodeficiency virus (HIV) infection in adolescents
- Acquired immunodeficiency syndrome (AIDS) survival rates

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)
Weighting According to a Rating Scheme (Scheme Given)

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

**Quality of Evidence for Recommendation**

I. Evidence from one or more properly randomized, controlled trial
II. Evidence from one or more well-designed clinical trial without randomization; from cohort or case-controlled studies
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

### METHODS USED TO ANALYZE THE EVIDENCE

Review

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

External Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The quality of evidence (I-III) is defined at the end of the "Major Recommendations" field.

#### Identification of Human Immunodeficiency Virus (HIV) Infected Adolescents

- Clinicians should provide HIV counseling for all adolescents and recommend HIV testing to sexually active adolescents when they present for care. (**III**)
- Clinicians should obtain a sexual risk history at the annual physical examination. (**III**)
- Clinicians should assess risk issues, including sexual activity and substance use, as well as home environment, history of violence, involvement in foster care, family history, and school, for those in care or undergoing HIV pre- and post-test counseling. Questions regarding physical and sexual abuse, sexual assault, and suicidal ideation, gestures, or attempts should be asked. (**III**)
- An adolescent who exhibits symptoms of major depression or symptoms of other severe psychiatric disorders during the HIV counseling process should be referred immediately for mental health services. If there is an acute risk of suicidal behavior, HIV testing should be deferred until the risk has been appropriately addressed. (**III**)
- Clinicians should be knowledgeable about New York State laws pertaining to adolescent consent and confidentiality and should educate their patients about these laws. For more information on a minor's rights regarding consent and confidentiality, refer to Appendix A in the original guideline document. (**III**)
- Clinicians who care for HIV-infected youths should develop referral agreements with testing sites where youths are initially diagnosed with HIV disease. (**III**)
- The clinician should identify a supportive adult to whom the adolescent can safely disclose HIV-related information. (**III**)

#### Baseline Medical History of HIV Infected Adolescents

- During baseline visits, clinicians should obtain a complete medical history (refer to Table 1 below). (**III**)
- The sexual history of a sexually active adolescent patient should focus on risk assessment, including the number of recent sexual partners, whether the patient currently has any sexual partners, and, if so, whether or not there are multiple partners or one stable partner. Clinicians should offer assistance with partner notification if needed. (**III**)
- Youths should be informed of the New York State Partner Notification Law as it pertains to HIV-infected individuals during HIV counseling process and prior to obtaining consent for testing (see Appendix B in the original guideline

document). Providers should also offer assistance in disclosing HIV status to sexual and needle-sharing partners. (**III**)

**Table 1**

**Elements of a Baseline History for HIV-Infected Adolescents**

**Reason for referral**

**Reason for choosing to have an HIV test or length of time that the adolescent has been aware of his/her HIV status and has been in care**

**Assessment of current HIV-related symptoms**. The clinician should also identify symptoms that might suggest acute HIV infection.

**Past medical history**, including major and childhood illnesses, medications, psychiatric history, hospitalizations, allergies, immunizations, and history of tuberculosis (TB) or TB exposure

**Sources of past medical care**

**Review of systems**, including menstrual history

**Growth and development**

**Social history**

- Living situation
- Sources of emotional and social support, including social service agencies and counselors and, if relevant, persons who know of HIV status; identification of a supportive adult with whom adolescent can disclose and discuss HIV-related information
- Family medical and psychological history, including access to health care and custody arrangements
- Peer relationships
- Education, learning disabilities
- Employment status
- History of violence
- Legal status (emancipated*)
- Legal problems
- Citizenship, immigration status

**Sexual history**

- Age at initiation of sexual intercourse
- Pattern of sexual relationships, number and gender(s) of sexual partners
- Sexual practices (oral, anal, vaginal)
- Disclosure to partner(s) of known HIV status**
- Contraceptive history and current practices, specifying frequency and condom use
- Self-assessment of safer sex practices
- Pregnancy history
- Sexual abuse (personal or family)

| Table 1<br><br>Elements of a Baseline History for HIV-Infected Adolescents |
|---|
| • Sexually transmitted diseases (STDs)<br><br>**Tobacco use history**<br><br>**Substance use history**, history of use and abuse of alcohol, marijuana (THC), cocaine, crack, methamphetamines, ecstasy, opiates, steroids, hormones, and other substances, including identification of type, route, specifying injection history--amount, frequency, and treatment history<br><br>**Dietary history** |

*In New York State, examples of when a minor might be considered emancipated are as follow: if he/she is married, he/she is in the armed forces; he/she has established a home and is financially independent.

**If HIV status has not yet been disclosed to partner(s), the clinician should offer assistance with partner disclosure.

### Baseline Physical Examination for HIV-Infected Adolescents

- During baseline visits, the clinician should perform a full physical examination with emphasis on HIV-associated manifestations (refer to Table 2 below). The examination should include an external genital, breast, and axilla examination using the Tanner rating scale for sexual maturity and perianal inspection of male and female patients. A pelvic examination including sexually transmitted diseases (STD) screening is indicated for female patients who have had sexual intercourse, ask for a pelvic examination, or have an unexplained gynecologic problem. (**III**)
- A mental status examination should be performed, which includes assessment of general mood, depression, suicidal ideation and attempts, and an abbreviated examination for cognitive function. (See the New York State Department of Health AIDS Institute publication *Mental Health Care for People With HIV Infection* for further guidance.) (**III**)

| Table 2<br>HIV-Specific Elements of a Comprehensive Physical Examination for HIV-Infected Adolescents |
|---|
| **Vital signs**, including assessment of pain<br><br>**Dermatologic examination**<br><br>• Examine for all skin conditions, including the following:<br>  • Seborrheic dermatitis<br>  • Psoriasis<br>  • Maceration of the gluteal cleft<br>  • Kaposi's sarcoma<br>  • Molluscum contagiosum<br>  • Onychomycosis |

**Table 2**
**HIV-Specific Elements of a Comprehensive Physical Examination for HIV-Infected Adolescents**

- Diffuse folliculitis with pruritus

**Lymph node examination**

- Examine for the following:
  - Supraclavicular and axillary nodes
  - Clusters of large nodes
  - Asymmetric nodes
  - Sudden increase in size or firmness of nodes

**Funduscopic examination**

- Examine for the following:
  - Cytomegalovirus retinitis
  - HIV-related retinopathy

**Oral examination**

- Examine for the following:
  - Oral candidiasis (thrush)
  - Hairy leukoplakia
  - Kaposi's sarcoma
  - Gingival disease
  - Aphthous ulcers
  - Periodontal disease
  - Oral herpes simplex

**Chest examination**

- Examine for the following:
  - Heart rhythm
  - Lung fields for wheezes, rhonchi, rales, or dullness
  - Heart murmur, click, or rub

**Abdominal examination**

- Examine for the following:
  - Hepatosplenomegaly
  - Multiple lipomata in the subcutaneous fat
  - Increased visceral fat

**Genital examination**

- Examine for the following in both males and females:
  - Venereal warts (HPV)
  - Classic and atypical herpes simplex virus (HSV)
  - Ulcerative genital disease
- Perform a careful pelvic examination and Papanicolaou (Pap) smear in

**Table 2**
**HIV-Specific Elements of a Comprehensive Physical Examination for HIV-Infected Adolescents**

females.
- Assess sexual maturity according to Tanner scale.

**Rectal examination**

- Rectal examination for visible anal lesions or evidence of skin abnormality around the anus
    - Consider obtaining an anal Pap smear in men and women with visible anal lesions or evidence of skin abnormality around the anus.

**Neurologic examination**

- Examine for sensory and motor abnormalities, cerebellar function.
- Mental status examination, including cognitive assessment, orientation, registration and recall, attention/calculation, and language (naming, repetition, command)
- Screen for depression and anxiety.

### Baseline Laboratory Evaluation

- When performing laboratory tests for HIV-infected adolescents, clinicians should follow guidelines for adults. (New York State Department of Health (NYSDOH) AIDS Institute, 2003; Department of Health and Human Services & Henry J. Kaiser Family Foundation, 2002) (**III**)
- Clinicians should perform baseline laboratory tests for HIV-infected adolescents which include immunologic and virologic assessment, evaluation for tuberculosis, STD screening, hepatitis antibody panels, and other baseline tests (refer to Table 3 below). (**III**)

**Table 3**
**Baseline Laboratory Tests for HIV-Infected Adolescents**

**HIV antibody test**

Retesting should be provided if written documentation of the positive test result or detectable viral load is not available, if an initial positive test has not yet been confirmed, or if the patient requests it.

**Immunologic assessment**

CD4 lymphocyte count, both absolute count and percentage; to produce reliable results, the same testing laboratory should be used consistently.

**Virologic assessment**

- Quantitative HIV-ribonucleic acid (RNA) testing for viral load assessment (performed twice using the same testing method)
- Genotypic resistance testing should be performed 1) prior to initiating

**Table 3**
**Baseline Laboratory Tests for HIV-Infected Adolescents**

treatment in anti-retroviral (ARV) therapy-naïve patients to determine whether they were infected with drug-resistant virus, and 2) in patients experiencing virologic failure or incomplete viral suppression while receiving ARV therapy. (Refer to the National Guideline Clearinghouse (NGC) summary of the New York State Department of Health (NYSDOH) guideline Antiretroviral Therapy).

**Tuberculosis evaluation**

- Purified protein derivative (PPD) skin test, 5TU (not necessary for a patient with a known positive or previously documented tuberculosis [TB])
- Chest x-ray if PPD is positive

**Additional baseline tests**

- Urinalysis
- Complete blood count (CBC), including differential
- Serum liver enzymes, creatinine, blood urea nitrogen (BUN), total protein, and albumin
- *Toxoplasma gondii* antibody screening
- Hepatitis A antibody screening for men who have sex with men, injecting drug users, those from an endemic area, and those with liver disease
- Hepatitis B antibody screening
- Hepatitis C antibody screening
- Varicella antibody screening
- Serum creatine phosphokinase (CPK), amylase and lipase, cholesterol levels, and triglycerides (if not initiating ARV treatment, these tests can be deferred)

**Tests for sexually active adolescents***

- Cervical Papanicolaou (Pap) smear**
- Culture or deoxyribonucleic acid (DNA) amplification test for gonorrhea (depending on the sexual behaviors reported or suspected, oral and anal cultures may be indicated, as well as cervical or urethral cultures)
- Rapid plasma reagin (RPR) or Venereal Disease Research Laboratory test (VDRL) for syphilis with verification of positive test by confirmatory fluorescent treponemal antibody absorption test (FTA-Abs) or microhemagglutination assay-*Treponema pallidum* assay (MHA-TP)
- Immunofluorescence or DNA amplification test for chlamydia
- Wet preparation for trichomonads, clue cells, and leukocytes
- Herpes simplex virus cultures as indicated
- Potassium hydroxide (KOH) preparation for "whiff" test and *Candida hyphae*
- Pregnancy test as indicated

*STD screening is equally important for both male and female adolescents.

**The NYSDOH AI recommends that Pap smears be performed at least annually in HIV-infected women as long as the results are normal. Women with abnormal Pap smears should receive more frequent follow-up, with repeated Pap smears every 3 to 6 months until there have been two

successive normal Pap smears. The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap smear, a repeat examination at 6 months, and then annually thereafter. The American College of Obstetrics and Gynecology (ACOG) recommends Pap smear every 6 months for HIV-infected women.

### Ongoing Medical Evaluation

- Adolescents should receive a comprehensive annual examination including a complete physical examination. (**III**)
- Adolescents should be seen for routine visits at least every 3 months. An interim history of HIV-related symptoms, ongoing risk behaviors, and psychosocial issues should be obtained during each routine visit. (**III**)
- Laboratory evaluations should occur on a routine basis (refer to Table 4 below). (**III**)
- The clinician should regularly discuss birth control, safe sex, and partner disclosure with patients, and should offer to assist with partner disclosure.(**III**)
- When ARV therapy is indicated but the youth chooses not to accept it, each routine visit should be viewed as an opportunity to review treatment options. (**III**)

**Table 4**
**Ongoing Laboratory Tests**

**Immunologic assessment (every 3 to 4 months)**

CD4 lymphocyte count and percentage; to produce reliable results, the same testing laboratory should be used

**Virologic assessment (every 3 months)**

- Quantitative HIV-RNA testing for viral load assessment (this should be performed more frequently if clinically indicated); the same testing method should be used. HIV genotypic/phenotypic resistance testing is indicated when treatment failure is suspected.

**Tuberculosis evaluation (annually)**

- PPD skin test
- Chest x-ray for patients known to have a history of TB or known to be PPD positive

**Tests for sexually active adolescents (every 6 months or if STD-related symptoms are present)**

- Pap smear*; colposcopy, if dysplasia is noted
- Culture or DNA amplification test for gonorrhea
- Immunofluorescence, or DNA amplification test for chlamydia
- RPR or VDRL screening test for syphilis (at least annually)
- Wet preparation for trichomonads, clue cells, and leukocytes
- KOH preparation for "whiff" test and *Candida hyphae*

| Table 4<br>Ongoing Laboratory Tests |
| --- |
| • Pregnancy test, as indicated<br><br>**Complete blood count (every 3 months)**<br><br>**Serum creatinine, BUN, total protein, albumin (every 3 months)**<br><br>**Additional ongoing tests for patients receiving ARV therapy**<br><br>• Serum CPK, serum liver enzymes, amylase, lipase, cholesterol levels, triglycerides |

*The NYSDOH AI recommends that a Pap smear be performed at least annually in HIV-infected women, and those with a history of an abnormal Pap smear should receive more frequent follow-up, with repeated Pap smears at least every 6 months. The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap smear, a repeat examination at 6 months, and then annually thereafter. The American College of Obstetrics and Gynecology (ACOG) recommends Pap smear every 6 months for HIV-infected women.

### Ongoing Psychosocial Intervention

The clinician should play a central role in coordinating a multidisciplinary care approach for the HIV-infected adolescent. (**III**)

Ongoing assessments of the adolescent's housing situation, education, family, sexual partners, safe sex practices, drug use (if applicable), and the adolescent's parenting skills (if applicable) should be integrated into the adolescent's medical care. (**III**)

When making referrals to drug treatment programs, community-based organizations, and counseling and support programs, the clinician should try to identify agencies with adolescent-focused services. (**III**)

Clinicians should be familiar with New York State laws pertaining to an adolescent's right to consent for certain forms of health care. (Feierman, Lieberman, & Chu, 1998; English, 1998; New York State Public Health Law, #27850(5), 1993; New York State Public Health Law, #2504(4), 1993) (**III**)

### Special Populations

- Clinicians working with HIV-infected youths should develop skills to work with adolescents with special needs, including perinatally infected adolescents, gay adolescents, transgender adolescents, pregnant adolescents, substance-using adolescents, and homeless adolescents. (**III**)

### Perinatally Infected Adolescents

- Perinatally infected adolescents should be assessed for HIV transmission risk behaviors regardless of their developmental stage. The interventions

employed for risk reduction should be individualized for the adolescent's developmental stage. (**III**)
- Perinatally infected adolescents have the capacity to understand the meaning of an HIV diagnosis and should be informed of their diagnosis if disclosure has not already occurred during childhood. (**III**)
- The clinician should begin to shift from discussing treatment with the family/caregivers to directly discussing treatment with the perinatally infected adolescent in an age-appropriate manner. (**III**)
- If an adolescent makes an educated informed decision to discontinue treatment the clinician should respect that decision. (**III**)
- Sexuality, contraception, substance use, gynecology, and adolescent treatment adherence patterns, should be discussed. (**III**)
- Pediatricians caring for perinatally infected adolescents should provide or refer for certain clinical services, including gynecologic examinations, contraception/family planning, STD screening, substance use assessment and treatment, and adolescent-focused mental health services. (**III**)

**Gay Adolescents**

- Clinicians should perform a comprehensive psychosocial assessment of gay adolescents and should facilitate referrals for mental health care when indicated. (Gionsiorek, 1989; Remafedi, 1994; Ryan & Futterman, 1998) (**III**)
- The clinician should be part of a support network for a gay adolescent who is more likely to experience feelings of alienation, rejection, and ostracism as compared to his/her same-age heterosexual peers. (**III**)
- The clinician should be able to counsel the gay adolescent about issues of disclosure of his/her sexuality as well as his/her HIV status. If necessary, the clinician should facilitate safe disclosure to parents and other family members. (**III**)
- Clinicians should be able to counsel gay youths on risk reduction in a manner that is non-judgmental and is consistent with the youth's sexuality. (**III**)
- Clinicians should screen gay youths for sexually transmitted diseases yearly and more often if necessary. (**III**)
- Clinicians should be able to detect the warning signs of adolescent suicide by directly asking questions about whether patients are feeling depressed or isolated, whether they have supportive individuals to whom they can turn, and whether they have had any recent suicidal ideation or gestures. (**III**)

**Transgendered Adolescents**

- Clinicians working with transgendered youths should be capable of addressing the specific issues associated with this population, such as mental health, gender identity, hormonal therapy, and sexuality needs. (**III**)
- Clinicians should obtain a gender identity assessment and inquire about hormone use in transgendered patients. (**III**)

**Pregnant Adolescents and Adolescent Parents**

- Clinicians should discuss options with patients who are making decisions about carrying pregnancy to term or terminating pregnancy. (**III**)

- Clinicians should advise pregnant adolescents who choose to carry pregnancy to term about the benefits of ARV therapy in reducing perinatal transmission. (Kurman et al., 1994; Public Health Service Task Force, 2002) (**I**)
- Clinicians should have referral agreements with obstetrical services that can provide care to HIV-infected women during pregnancy; however, the clinician may want to continue to be the primary care provider for the adolescent during the pregnancy (refer to the NYSDOH AIDS Institute's *Management of HIV-Infected Pregnant Women Including Prevention of Perinatal HIV Transmission* for further guidance). (**III**)

**Adolescent Substance Users**

- Clinicians should be familiar with programs that provide drug detoxification and maintenance as therapeutic modalities. (**III**)
- Clinicians should be able to detect alcohol and marijuana use and should be able to provide counseling as well as referral for treatment. (**III**)
- Clinicians should be familiar with both harm reduction-based and abstinence-based drug treatment programs for the purposes of referral. (**III**)
- Clinicians should be aware of drug interactions between HIV-related medications and illicit drugs. (**III**)

**Homeless Adolescents**

- Clinicians should work closely with case managers and social workers to help homeless youths find appropriate housing. (**III**)

**Definitions**:

**Quality of Evidence for Recommendation**

I. Evidence from one or more properly randomized, controlled trial
II. Evidence from one or more well-designed clinical trial without randomization; from cohort or case-controlled studies
III. Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Overall Potential Benefits

Appropriate identification and ambulatory care of human immunodeficiency virus (HIV)-exposed and -infected adolescents

#### Specific Potential Benefits

The purpose of the sexual history and risk behavior assessment is to enable the clinician to provide appropriate risk reduction education, including a discussion of safer sex practices. The intention of this counseling is to prevent further HIV transmission as well as the possible acquisition of resistant HIV.

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

#### Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

#### Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AIDS Education and Training Centers (AETC). The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides

conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

### IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness
Staying Healthy

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents. New York (NY): New York State Department of Health; 2004 Nov. 22 p. [21 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

## DATE RELEASED

2003 (revised 2004 Nov)

## GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

## SOURCE(S) OF FUNDING

New York State Department of Health

## GUIDELINE COMMITTEE

Not stated

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents. New York (NY): New York State Department of Health; 2003. 21 p.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

## AVAILABILITY OF COMPANION DOCUMENTS

This guideline is available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI on February 3, 2005. This NGC summary was updated by ECRI Institute on September 19, 2007.

### COPYRIGHT STATEMENT



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